



an initiative of 99 Balloons, Inc.

To fill this out on your computer, you must use Adobe Reader.

Parent/Guardian Information

Child's Name

Child's Primary Diagnosis *(please be specific)*

Mother

Father

Guardian

First Name

Last Name

Address

City

State

Zip

Email Address

Home #

Cell #

Mother

Father

Guardian

First Name

Last Name

Address (if different from above)

City

State

Zip

Email Address

Home #

Cell #

Mobile Phone Number(s) in use while child is at rEcess:

(please be sure to leave this contact number during rEcess Check-In)

ex: Year Aug 2015 Signature Jane Doe

Year _____ Signature _____ Year _____ Signature _____ Year _____ Signature _____

Emergency Information

In the event of an emergency, the following person may be called and is authorized to pick up my child.

(Positive identification must be provided before your child will be released.)

Name Relationship
Mobile Number

In the event of an emergency, I give the rEcess staff or any emergency medical personnel permission to transport my child to the nearest hospital for medical treatment in the event that I cannot be located. I consent for necessary emergency treatment by the medical staff for my child in the event I cannot be reached to make arrangements at the time of illness or accident.

Child's Full Name Child's SSN
Date of Birth Place of Birth
Date of last Tetanus

Please list all known drug allergies:

Please list any medications that are taken on a regular basis:

Will medication be needed during rEcess? No Yes

If yes, please complete the Release for Administration of Medication form.

Insurance Information

Insurance Carrier Policy #
Group # Insurance Phone #

If insured is different from child::

Insured's Name SSN
Relationship to Child

Primary Physician Address
Physician Phone
Preferred Hospital Address

Does insurance information apply to all children? Yes No

If no, please include insurance information on the Sibling Form(s).

Party Responsible for Payment::

Name Relationship to Child
Address
City State Zip
Employer
Home Number Work Number

Parent/Legal Guardian Signature: **Date:**

Sibling Information

Please list all siblings attending rEcess::

Sibling 1:

Name

Age

Date of Birth

Sibling 2:

Name

Age

Date of Birth

Sibling 3:

Name

Age

Date of Birth

Sibling 4:

Name

Age

Date of Birth

Sibling 5:

Name

Age

Date of Birth

Please complete the additional "Sibling Info Form" to provide additional details and information for each sibling.

Physical Needs

Vision: Normal Impaired Blind

Hearing: Normal Impaired Deaf Hearing Aid

Motor: Head Control Rolls Over Sits Crawls Cruises
 Walks Walker Crutches Braces Wheelchair

Toileting Skills: Toilets independently Wears a diaper Needs Help
 Being potty trained Potty trained, needs assistance

Staff can help by:

Eating Habits:

No Restrictions Can take nothing by mouth Soft foods only Bottle

Staff can help by:

Food & Environmental Allergies (please list all, e.g. wheat, dairy, cedar, cats, etc):

Communication

Communicates with:

- | | | | |
|------------------------------------|--|----------------------------------|-----------------------------------|
| <input type="checkbox"/> Words | <input type="checkbox"/> Babbles | <input type="checkbox"/> Phrases | <input type="checkbox"/> Gestures |
| <input type="checkbox"/> Sentences | <input type="checkbox"/> Sign Language | | |

Other (Please describe):

Can understand what others say:

- | | | |
|---------------------------------------|---|---|
| <input type="checkbox"/> All the time | <input type="checkbox"/> Most of the time | <input type="checkbox"/> Some of the time |
|---------------------------------------|---|---|

Behavior:

- | | | |
|---|---|--|
| <input type="checkbox"/> Outgoing | <input type="checkbox"/> Shy | <input type="checkbox"/> Plays in groups |
| <input type="checkbox"/> Adapts to new situations well | <input type="checkbox"/> Adapts to new situations with difficulty | |
| <input type="checkbox"/> Responds to correction well | <input type="checkbox"/> Responds to correction with difficulty | |
| <input type="checkbox"/> Sometimes threatens others | <input type="checkbox"/> Sometimes hits, bites or hurts self/others | |
| <input type="checkbox"/> Sometimes attempts to run away | <input type="checkbox"/> Hyperactive and/or ADD | |

My child responds to separation from his/her parents by:

My child is best comforted by:

My child lets someone know what he/she wants or needs by:

Misc.

My pet's name is:

Favorite Toy:

Favorite Stuffed Animal:

Favorite Color:

Activities my child likes (music, coloring, group activities, independent play, etc):

Fears or dislikes (i.e. dogs, balloons, loud noises, etc):

My child needs encouragement to:

Please do not ask my child to:

My child learns best when:

My child participates more when:

Permission/Authorization Agreement

Please read the following statements carefully and initial in the designated space indicating that you have read, understand, and agree to the provisions.

I understand that rEcess is a “free source initiative”; therefore, although each rEcess program adheres to some fundamental practices, **99 Balloons, Inc. does not oversee nor ensure the safety of each rEcess program.**

Questions regarding policies and safety concerns should be presented to the Leadership Team for your specific rEcess. All rEcess logos, best practices and policies are distributed freely as a tool to individuals and organizations seeking to assist the special needs community. Each Leadership Team is empowered to tailor their rEcess program to their facility and community. With that said, feel free to contact us at info@99balloons.org in the event of concerns in need of reporting.

I have fully disclosed to rEcess all pertinent facts about my child’s special needs and accept full responsibility for failure to do so.

I will supply all necessary food, drinks, snacks, and diapers/wipes for my child.

In the case of an emergency or accident, I understand that EMS (911) will be called. I authorize EMS to administer any medical treatment, medication, or appliance deemed necessary by EMS. I also authorize transportation by EMS to the nearest appropriate medical facility, as determined by EMS. I understand that I will be responsible for payment of all EMS, hospital and physician charges for emergency services to my child.

Publicity Release

rEcess is a respite care program designed to lessen the stress of families caring for a child with special needs. Because we will want to reach as many families as possible, we may publicize the program through television, radio and newspapers. The use of your name, your child's name and/or picture is strictly voluntary. If you want to participate in our effort to help other families learn about rEcess in the future, please sign below.

I consent for my child/children to be photographed. The pictures may be used for press releases, journal articles, or other positive publicity related to respite programs.

Parent/Guardian Signature

Date